Private medical fees investigated

The BMA's guidelines on consultants' fees for private work have prompted the Office of Fair Trading to investigate how consultants set their charges. Sir Bryan Carsberg, director general of fair trading, asked the Monopolies and Mergers Commission (MMC) last week to decide whether the guidelines contravene the Fair Trading Act 1973 by producing a "complex monopoly." The act defines this as a situation that exists "if a group of two or more persons . . . restrict or distort competition in connection with the supply of goods or services." The MMC will take 12 months to report to the Secretary of State for Trade and Industry.

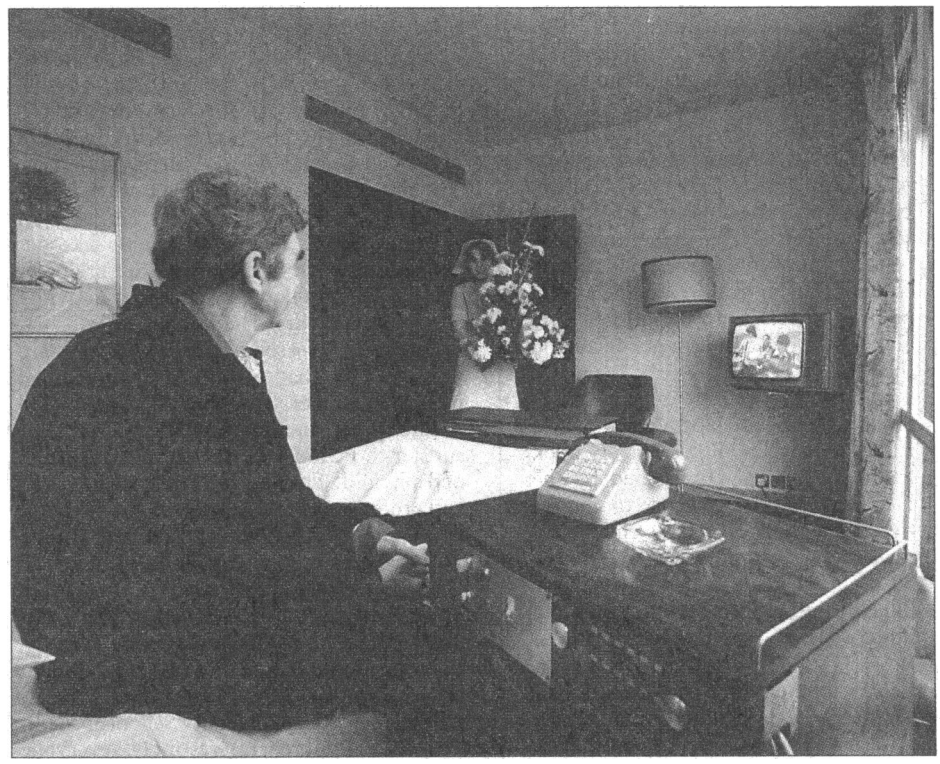
The BMA's guidelines were first produced in 1989, four years after the annual representative meeting asked for a working party to produce a fee schedule for private work. The latest edition, published this month, lists consultants' charges for 1500 procedures. Surgeons' fees range from £120 for an adenoidectomy to £5825 for liver transplantation. Anaesthetists' fees are usually less than half that rate.

The MMC says that its investigation does not arise from a specific complaint. "It was just something that came to our attention," said a spokesman. "We have a duty to monitor various guidelines. Maybe we read about it in the trade press. We are not saying that there is an anticompetitive effect—that this was a nasty practice. It's up to the MMC to investigate thoroughly."

But the BMA claims that its guidelines cannot constitute a monopoly because they are just advisory. The introduction to the guidelines states, "It is essential to stress that this document is only to be used by practitioners as a guide. Consultants must decide themselves on what the appropriate fee is for the service provided." The guidelines emphasise that the costs listed are what a "typical consultant would charge."

The MMC's investigation comes at a time when private medical insurers are raising the price of insurance premiums above the level of inflation. The industry has been enthusiastic about the MMC's involvement, claiming that the BMA's guidelines have become a baseline for consultants' charges and have effectively eliminated fee competition.

"The level of consultants' fees and the difficulty of influencing them is of continuing concern because they amount to 32% of all the claims we meet," said Roy Forman, chief executive of Private Patients Plan, the second largest private health insurer. "We feel that it is inadvisable to publish guidelines of this nature because they become a target for those who charge less and those who charge more will not reduce their charges to the guideline level."



PHILIPPE ACHACHE/IMPACT

Medical charges are usually less than other costs in private care

Private Patients Plan does not have a list of payment rates for consultants. It pays what it considers to be "reasonable charges," and its statement to the media on the MMC's investigation says that "most specialists charge reasonable fees."

British United Provident Association (BUPA), however, does have a list of payments, and the BMA claims that it was this list that prompted its guidelines. "We knew that we could get referred to the MMC, but we decided to go ahead and produce guidelines in the public interest and the interest of our members," said Mr Richard Marcus, deputy chairman of the BMA's private practice committee. "We wanted the guidelines to produce a managed market rather than chaos. GPs can use them to discuss the likely cost of private care with their patients. They are there to promote good practice."

BUPA, however, claims that there is a big difference between its guidelines and the BMA's guidelines. "Our contract is between the subscriber and ourselves," said David Bryant, BUPA's public relations manager. "We let them know how much we will pay. Our information is directed to our customers. The BMA's scale is directed at members of the BMA. Our experience is that medical inflation runs at double the rate of retail inflation. Premiums on our main schemes are up by about 20% this year."

The private insurers have also been hit by an increase in the number of claims. David Bryant said that of each 100 subscribers, 15 had made insurance claims in 1990. In 1991 this figure had increased to 18.

But Mr Marcus believes that the contribution of medical charges to the rising insurance premiums is often exaggerated. "Medical charges are usually less than the other costs incurred in the treatment episode, and we feel that there has been an unhealthy publicity about medical costs which tends to obscure the debate about the cost containment problems facing the private sector," he said. "Our charges are quite sensitive. I charge £50-60 for a domiciliary visit. A call out for an engineer to change a fuse in my house is about £40."—LUISA DILLNER, *BMJ*

Alzheimer's debate gets major airing

An important research journal, *Neurobiology of Aging*, has devoted its entire September issue to the role of the β amyloid protein in Alzheimer's disease. In question are the results of Bruce Yankner and Neil Kowall, of Harvard University, who claimed that injections of β amyloid into rat brains caused nerve cell degeneration similar to that seen

Headlines

Department of Health withdraws vaccine: Pluserix MMR and Immravax—two brands of vaccine used to protect children against measles, mumps, and rubella—have been withdrawn following concern that they were linked to viral meningitis. The chief medical officer is writing to all doctors telling them to use the MMR II brand.

Tougher measures against violent offenders: From 1 October courts will be able under the Criminal Justice Act 1991 to impose longer sentences to protect the public from violent and sexual offenders. More emphasis will be put on work with the offenders to tackle their behaviour in prison and on their release.

"Kill your speed. Not a child": This is the new slogan of a £2.3m, six week television campaign launched by the Department of Transport to reduce the annual toll of 45 000 child road casualties. Research has shown that at 20 mph (32 km/h) one child in 20 is killed; at 40 mph (64 km/h) most are killed.

Fall in cot deaths: The number of deaths from the sudden infant death syndrome has fallen in Scotland from 160 in 1981 to 131 in 1990 and 89 in 1991. According to the General Register Office the decline started before the issue of official advice on infant care associated with a decline elsewhere, and the office recommends further investigation.

Scottish royal colleges: The Royal College of Physicians and Surgeons of Glasgow, the Royal College of Physicians, and the Royal College of Surgeons of Edinburgh have united to form the Scottish Royal Colleges. A committee of nine, chaired by Dr Anthony Toft, will advise and represent all the colleges.

New health and safety regulations: Regulations have been laid in parliament to implement the EC directive to improve the health and safety at work. They will come into force on 1 January 1993 after consultation. Employers will have to assess the risk to the health and safety of employees.

US women told to take folic acid supplements: All women of childbearing age have been told by the US Public Health Service to take more folic acid to decrease the risk of birth defects. This is the first time that the US government has supported the use of vitamin supplements for the general population.

in the brains of patients with Alzheimer's disease. Other researchers, however, failed to replicate those results, leading to confusion and animosity in the world of Alzheimer's research.

Yankner's claim was important for two reasons. Firstly, it provided some understanding of what β amyloid was doing in Alzheimer's disease. Back in 1984 George Glenner and C W Wong at the University of California at San Diego had shown that the senile plaques characteristic of the brains of Alzheimer's patients contained a core of β amyloid protein. Ever since, debate has raged about whether β amyloid is the cause of nerve cell degeneration or merely an effect. Initially, Yankner showed that β amyloid was toxic to nerve cells in culture. He went on to show that it created Alzheimer-like degeneration when injected into the brains of healthy rats. On that basis, he gave β amyloid a causative role in Alzheimer's disease.

The second reason Yankner's findings are important is that they offered an animal model. Yankner and his colleagues discovered that another small brain protein, substance P, blocked the neurotoxic effects of β amyloid. That suggests that substance P, and other compounds like it, might be useful in treatment, and the use of β amyloid offered a way of screening potential treatments.

Other laboratories tried to replicate Yankner's results, and failed. "The basic story is that the effects originally seen by Yankner, Kowall, and coworkers have been far from reproducible," says Sam Sisodia, of Johns Hopkins University School of Medicine in Baltimore. Interestingly, everyone agrees that β amyloid is toxic to nerve cells in culture. It is the effects of injection that are unclear, apparently varying with the source of the β amyloid and the solvent used.

In fact, the special issue of *Neurobiology of Aging* has four papers in support of Yankner and four against, but that effectively damns the result. As Sisodia and a colleague, Donald Price, write in a summary paper: "If neurotoxicity cannot be produced reliably and unequivocally, then it seems unlikely that this model will be useful for analysing pathogenic mechanisms... or for testing therapeutic strategies."

That last remark offers an insight into the extreme rancour that Yankner's claims have engendered because several of his critics are associated with Athena Neuroscience, a company actively trying to develop models and drugs for Alzheimer's. Three of the four who failed to replicate are tied up with Athena in different ways, and Yankner has implied that they have been so vocal because they are unhappy with the idea of anyone beating them to an animal model. Yankner's critics deny this and say that Yankner's conclusions went beyond his data and that at first he was less than forthcoming with the details needed to copy his experiments exactly.

It was to cool tempers and sort out the science that Paul Coleman, editor of *Neurobiology and Aging*, decided to devote an entire issue to β amyloid. "Clearly this is a topic of consuming interest to the community, and that was the major consideration," Coleman said. The special issue gives unusually full details of experimental methods, which clarify who did what, and how, even if they do not clarify the actual role of β amyloid.

That role is bound to remain central. For now, Yankner is sticking to his guns, elaborating on the mechanisms by which β amyloid might have its effects. And his critics concede that β amyloid is toxic to nerve cells. "The question is whether any of the experiments have so far replicated the condition in the human brain," says Harvard's Dennis Selkoe. Further research, stripped of some of the animosity, should eventually provide the answers.—JEREMY CHERFAS, science writer, Bristol

Giving teeth to the Citizen's Charter

Personal social services, together with other local authority services, will come under the scrutiny of those who use them as never before—under a scheme proposed by the Audit Commission last week. Under the broad framework of the Citizen's Charter, the commission has produced draft performance indicators for local authority services that will allow the public to assess the quality of services and their cost effectiveness. As important as the indicators themselves, however, is the commission's general approach to identifying indicators.

The prime requirements for performance indicators, says the commission, are that they should cover matters of interest to citizens; include cost and economy; support comparisons both over time and between authorities; and be acceptable to service professionals. For this last reason it has avoided laying down predetermined standards. For example, a suggested indicator for personal

ULRIKE PREISS

Quality is hard to measure in personal social services

social services is the proportion of people allowed to enter long term residential care without having been previously given any other form of support. The commission does not suggest what a reasonable proportion is but comments that "an authority that is successful in identifying elderly people in need of help, and providing suitable services to meet those needs, will have relatively fewer clients in this category than an authority which is less successful.

Many of the potential indicators of most interest to citizens are to do with quality, which is notoriously hard to measure. For many services, therefore, the commission has suggested a pragmatic easily measured index of performance but wants to develop more complex indicators in future. Thus to assess how long disabled people have to wait for equipment they need to make life easier the commission suggests measuring the average length of time in response to requests for equipment. But it acknowledges that it would be desirable also to know how provision compared with need and the appropriateness of the equipment.

The commission would like comments on its suggested indicators and its general approach by 31 October. Authorities will then have to collect information on each indicator in 1993-4 and publish it locally. The Audit Commission itself will publish national summaries of the information.—JANE SMITH, *BMJ*

Citizen's Charter Performance Indicators (£5) is available from the Audit Commission, Lime Kiln Close, Stoke Gifford, Bristol BS12 6SU. Comments should be sent to the Audit Commission, 1 Vincent Square, London SW1P 2PN.

NANCY DURRELL McKENNA/PANOS

Having a baby can be expensive in Thailand

Infertility services uncontrolled in Thailand

Gynaecologists in Thailand are lobbying for the country's General Medical Council (GMC) to establish strict technical guidelines to govern treatment for infertile couples after reports of dangerous practices in Bangkok's many private medical clinics. The Association of Thai Gynaecologists (ATG) says that it has evidence of a growing number of women with serious complications after being treated by doctors with only the most basic knowledge of in vitro fertilisation (IVF) and gamete intrafallopian transfer (GIFT).

The ATG hopes to convene a seminar in Bangkok next March and intends to invite infertility experts from Europe and the US to discuss the problems of infertility treatment in Thailand and other developing countries. "I know of doctors who carry out operations when their only experience is watching the techniques for several days at clinics abroad," explained Dr Pramuan Virutamasen, director of the World Health Organisation's Centre for Collaborative Reproductive Research in Bangkok. "At ATG we are in the process of drafting our own guidelines for members. ATG does not have any punitive powers but the GMC does and we hope in time they will adopt tough guidelines."

Dr Virutamasen said that the GMC was setting up a committee to look into practical and ethical issues concerning assisted conception by Bangkok's private sector. The demand for services to help infertile couples had boomed in recent years because Thailand's emerging middle classes had more money to spend—the country's per capita gross domestic product doubled in the five years from 1986—and there was increasing awareness of advances in infertility treatment in the US and Europe, he added.

The IVF programme established by WHO and the Thai Red Cross treats up to four couples a week; the first successful operation was in 1987. As many as 1000 couples a year, however, seek assisted conception in Thailand. Clinics in Bangkok charge £900-£1200 for GIFT operations, with higher charges for IVF.

Dr Virutamasen said that the GMC and ATG were also keeping a close watch on some clinics which advertised that they could produce twins or choose the sex of the child. "We really do hope we can introduce standardisation in the level of services provided," he said.—FRED LENIHAN, freelance journalist, Bangkok

Radiology departments safe for pregnant workers

Pregnant women working in hospital radiology departments should not worry about radiation exposure harming their babies. In a report published last week the Royal College of Radiologists and the British Institute of Radiology reassure women that "There is no evidence to show that there is any significant risk of radiation effects to the fetus for staff working in radiodiagnostic departments."

Over 99% of all staff receive lower doses of radiation than those permitted for the general public, says the report, which quotes from a study of 6000 NHS employees. The public is exposed to an average of just under 2 millisieverts a year from a variety of sources, including cosmic radiation and naturally radioactive foods. Figures in the report show that 99·3% of radiographers receive less than 1 mSv a year at work.

Research looking specifically at radiation dose to the abdomen in people working in British radiology departments shows that even in a very busy job a fetus would receive only 0·2 mSv over a period of 20 days.

The report was prepared by a joint working party in response to staff concerns that radiation could harm their unborn children. Childhood cancer, fetal death, mental retardation, and an increase in inherited defects are all documented dangers of exposure to radiation, but most of the evidence comes from studies of high exposure such as the aftermath of atomic explosions.

Ultrasound and magnetic resonance imaging are probably harmless to pregnant women and the fetus, but as a precautionary measure the Department of Health recommends that women should keep out of the MRI scanning room in the first trimester.

Despite the reassurances, the joint working party emphasises that all staff should stick strictly to the local rules in order to keep occupational exposure at its current low level. "It is a legal requirement that every department has a set of local rules governing practice within controlled areas," says Dr Penny Roberts, consultant medical physicist and radiation protection advisor to Southampton University Hospitals. "This includes the wearing of dose meters in certain areas, standing behind screens as appropriate, and the wearing of protective clothing."

The report also recommends that staff who are monitored should always be told the radiation doses they are getting and that when a pregnant woman decides to avoid all radiation, her workload should be rescheduled wherever possible.

A separate working party from the Royal College of Radiologists has examined the use of magnetic resonance imaging in hospitals in

the UK. It recommends that all hospitals should have access to this facility. MRI scanning is more effective, less invasive, and less hazardous in respect of ionising radiation than other equivalent diagnostic tests, says the report.—ALISON TONKS, *BMJ*

Pregnancy and Work in Diagnostic Imaging is available from The British Institute of Radiology, 36 Portland Place, London W1N 4AT, price £5·00.

Centres for sexually abused children

Over 6300 children in Britain have been sexually abused but only half of local authorities have treatment facilities for them, said the National Children's Home (NCH) last week. The NCH—the second largest children's charity—is launching a £2 million campaign to fund a network of specialist treatment centres for five years.

Over the past two years the NCH has opened 11 centres for sexually abused children and their families. Five more centres are planned. The charity is also calling on the government to provide £6 million to give therapy to every sexually abused child on the child protection register.

The NCH says that its centres are the first to offer help for children and their families. "The centres will be run by social workers in partnership with health authorities," said Sandra Horniman, NCH's press officer. "The whole family will have the benefit of support on a day care basis. Psychiatrists will be brought in on a consultancy basis. Some of the centres are on hospital sites but most are in the community—they are homely places."

A survey performed by the NCH for the Department of Health in 1990 found that there were only a handful of centres offering specialist services to sexually abused children. "The trouble is that local authorities just do not have the funds to develop specialist centres. They tend to concentrate on investigating and disclosing the abuse rather than treating it," said Ms Horniman—LUISA DILLNER, *BMJ*.

NCH To protect confidentiality models are used

The NCH is spending £2 million on specialist services

Scotland's health: bad and good news

Heterosexual intercourse has become the most common source of HIV infection in Scotland, the country's Chief Medical Officer, Dr Robert Kendell, said as he presented his annual report for 1991.

Dr Kendell described the rise in infections acquired heterosexually as "deeply worrying." Although the number of cases remains small, the potential for a further, serious spread of the virus is high, particularly as many sexually active members of the public do not consider themselves at risk.

In the 12 months to June of this year there were 151 new cases of HIV infection in Scotland. Of these, 51 were classified as heterosexual cases, 40 involved homosexual intercourse, and 39 were cases in which injecting drug use was the mode of transmission. The number of infections acquired by heterosexual transmission has increased by 7% from 1990. "Our job is to convince ordinary young people that they are at risk. These figures show that they are," said Dr Kendell.

On a more positive note, his report recorded several improvements in health, suggesting that Scotland is slowly shaking off its image as one of the world's most unhealthy countries. Heart disease mortality among middle aged men has fallen by 12% in the past two years, although rates among women have remained static. "At last we have clear evidence in Scotland of the falling mortality from coronary heart disease, previously observed in other countries like the USA and Australia," says the report. Dr Kendell attributed Scotland's high rates of heart disease and cancer to the high prevalence of smoking and poor diet. Recent reductions in smoking among men are credited with the improving heart disease statistics.

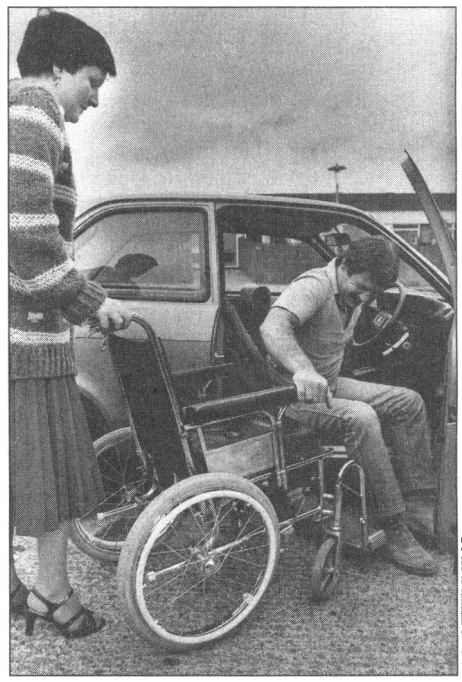
In addition, the infant mortality rate is the lowest ever recorded and the incidence of most childhood infections has fallen, mainly because of improvements in the immunisation programme.—BRYAN CHRISTIE, health correspondent, *The Scotsman*

Health in Scotland 1991 is available from HMSO bookshops, price £14.

Disabled drivers not getting advice from doctors

A survey for the Automobile Association (AA) has found that two thirds of people with a disability that affected their driving had received no advice about driving from their general practitioner. They included people with epilepsy, diabetes, and heart disease.

More than one in 10 people in Britain are registered disabled, and the report highlights the mobility problems that they face. Among the 1130 disabled people questioned by the AA most said that cars were the only suitable



JOHN TWINNING

Disabled drivers can feel anxious and unhappy

form of transport for them. Only one in five used public transport, and only one in 10 used a bus as their main means of transport. The main problem with both buses and trains was climbing up and down the high steps.

The report found that disabled people were unhappy with parking facilities and anxious about the pedestrianisation of towns and cities. According to Rayner Peatt, press officer for the AA, Milton Keynes is a good example of pedestrianisation for disabled people: the local authority provides special parking areas and hires out electric wheelchairs.

Half of the disabled people questioned in the survey were put off claiming the mobility allowance because they did not want a physical assessment. This assessment, in which a doctor must decide whether a person is capable of walking 100 yards, was judged "a humiliating experience" by some respondents and unfair by others: "[it] is one day, one hour in 365 days of the year," said one person quoted in the report.

The evidence that doctors were not advising patients about driving was worrying, said Dr Philip Jones, medical adviser to the Driving Vehicle Licensing Agency (DVLA) in Swansea, but it was possible that the advice had been given and forgotten by the patient. Dr Jones emphasised the need for doctors to record in medical notes that they had given advice in case legal action arose.

The DVLA grants "review licences" to people with potentially progressive mental or physical disabilities. Renewal depends on a favourable medical report every one to three years. People with disabilities that may affect their ability to drive must inform the DVLA. But, said Dr Jones, "it is the responsibility of the general practitioner or hospital doctor to advise the patient to inform the DVLA."—FIONA GODLEE, *BMJ*

Mobility for All. Disabled Travellers and Their Needs: a study by the Automobile Association is available free from Dr Steve Lawson, AA, Fanum House, Basingstoke, Hampshire RG21 2EA.

Perils of stoma sponsorship

ST BARTHOLOMEW'S HOSPITAL/SPL

Nurses should not be under pressure to promote products

No nurse should be put under pressure to recommend a certain company's products because her salary is paid for by that company, the Royal College of Nursing says in new guidelines on commercial sponsorship.

The college has revised its guidance in response to fears voiced by some stoma care nurses that they felt obliged to promote particular products because the company that made them was sponsoring their post.

The Campaign for Impartial Stoma Care has collected details of several cases where nurses felt sponsorship was compromising their clinical judgment, patients felt their choice had been limited, and companies believed other products had been prescribed in preference to their own because a post was sponsored. The campaign has sent them to the Department of Health. Tim Yeo, junior health minister, has promised to investigate the cases.

Mrs Wyn Caveen, who chairs the Royal College of Nursing's stoma care forum, says that sponsorship of nursing posts is increasing rapidly. Three years ago there were only three sponsored stoma care nurses. Now there are 30.

Mrs Caveen says, "Sponsoring companies give the health authority £20 000 to £30 000 to provide a service. They have got to get that money back—although they say that the nurse can use any company's products."

Mrs Caveen says that she knows of one instance where a company sponsored a post and then withdrew the funding because there were not enough patients. This disturbs her: "If companies target posts that are already there and then the post does not generate enough income for them and they pull out, will the health authority then take the funding over?"

She says that nurses have been reluctant to come forward with specific examples of cases where they feel obliged to recommend certain products. "We are not against sponsorship but we believe that direct sponsorship by a stoma care company of a stoma care post would limit the choice of products available to patients."

The Royal College of Nursing's guidelines say that employers should consider the benefits of commercial sponsorship to patients and staff "alongside any declared or undeclared benefit to the company," to ensure that patients and staff are not put at risk in any way.

Sponsorship of nursing posts by commercial companies may ensure that an existing service continues, or may allow a new service to be introduced. But, the guidelines say, "The motives of the sponsor are unlikely to be completely altruistic."

Patients and staff could suffer if the sponsorship were suddenly withdrawn, if there were breaches of confidentiality relating to the company's access to data on use of products, or if the clinical judgment of the nurse were compromised, the guidance says.

The college recommends that employers should consult nurses over proposed sponsorship arrangements, that sponsors should have no involvement in recruitment or selection of the holder of the sponsored post, and that the nurse should remain an NHS employee and should not be accountable in any way to the sponsor.

Mrs Caveen says that she believes the college's guidelines will improve the situation. "In the past, posts just became sponsored without any consultation with the nurse—it was take it or leave it."

The Campaign for Impartial Stoma Care has suggested setting up national or local ethics committees to vet sponsorship contracts. A spokeswoman said: "Sponsorship can be a good thing but it needs to be controlled. If you sponsor an orchestra, you don't dictate what they play."—SHARON KINGMAN, freelance medical journalist, London

Raising the quality of quality assurance

Quality assurance within the NHS has "demonstrable weaknesses," said the Audit Commission in a discussion document released this week. The commission believes that it should be able to "assist in bridging the gaps which are often apparent between theory and practical ways of securing higher quality."

The first weakness that the commission identifies is that too little attention is paid to patients' views. Thus research is commissioned with almost no input from patients, and when purchasers and providers do consult patients they often use unsound methods. Clinical audit rarely assesses patients' opinions of services, and community health councils are underresourced.

A second problem with NHS quality assurance is that it is often isolated professionally and geographically. W Edwards Deming, one of the founding fathers of total quality management, refers to one group or sector seeking to improve quality on its own as "suboptimisation." The isolation means that quality assurance enthusiasts keep "reinventing the wheel." The commission identifies two more problems with NHS quality assurance: a tendency to focus on what is easy to measure rather than on what is really important, and the insufficiently scientific nature of quality assurance activities.

The Audit Commission proposes to respond to these weaknesses by giving priority to the perspective of patients in its own activities. It now includes a patient on the advisory group for all its studies, and it will make sure that patients' priorities and needs are researched in every study. "Professionals articulating what they believe the patients' views to be is no substitute for the real thing," warns the document. The commission concedes that most of the studies it has conducted so far have been defined by professionals rather than patients, and it now wants to conduct some patient defined studies. New studies will include the care of sick children in hospital and of patients' views of how complaints are handled.

As well as building on what it already does, the commission might also take on new roles. One suggestion is that it develops a quality exchange as it has done for local authorities. The exchange would be voluntary and could provide access to a network of good practice; it could also allow purchasers and providers to compare themselves with each other. This possibility leads to the final suggestion, that the commission might publish league tables of authorities' performance. The discussion document is, however, very cautious about this suggestion: "For a great many clinical areas the tools to measure performance do not yet exist, and for those that do have measures the data need very careful interpretation."

The discussion document is being sent to all district general managers, unit managers, and interested parties, and responses are invited by the end of October.—RICHARD SMITH, *BMJ*

Minding the Quality: a Consultation Document on the Role of the Audit Commission in Quality Assurance in Health Care is available from the Publications Section, Audit Commission, Nicholson House, Lime Kiln Close, Stoke Gifford, Bristol BS12 6SU.

Halcion used as defence in Britain

A convicted killer who stabbed a fellow prison inmate 17 times after drinking tea spiked with the benzodiazepine Halcion has been acquitted of attempted murder, in the first British case to raise the side effects of the drug as a defence.

By a majority verdict a jury at the High Court in Edinburgh found the charge against James McLeod, who is 30, not proven after hearing that his tea had been drugged without his knowledge. Staff at Perth prison gave evidence that they witnessed the attack on 22 year old Paul McGuire in August last year, but McLeod, now in Peterhead jail, said that he had no recollection of the incident. Another prisoner told the court that he had slipped Halcion and an unidentified drug into McLeod's tea to calm him after rumours swept the prison that McLeod was about to be beaten up.

McLeod's counsel, Mhairi Richards, asked the jury to accept that he was entitled to rely on the "robot" or "temporary madness" defence, established in a historic Scottish appeal ruling last year. This established that automatism could be a complete defence to a charge, not just a mitigating factor affecting the sentence, if it was due to something external, such as drink or drugs, which was not self induced, which the accused did not foresee, and which caused a complete loss of self control.

The acquittal coincides with moves by an English businessman sentenced to seven years' imprisonment in Scotland for abducting and raping his wife while taking Halcion to reopen his case. The man, who cannot be named because of rules protecting rape victims' identity, is seeking permission to appeal three and a half years after his conviction. He pleaded guilty to the charges at the High Court in Edinburgh in March 1989 but contacted lawyers about an appeal after publicity over Halcion's withdrawal from the British market last October because of fears over side effects.

His lawyers will argue that he acted under the influence of the drug and was therefore not responsible for his actions. The appeal bid will be supported by an affidavit from Ian Oswald, former professor of psychiatry at Edinburgh University, who told the jury at the McLeod trial that the drug could produce bizarre behaviour, including paranoia and hallucinations.

The businessman had never been in trouble with the law before March 1988, when he assaulted his wife while taking Halcion. Three months later, again while taking the drug, he abducted her at gunpoint from Greenock to Huntingdon, where he raped her. The couple are now divorced.

Professor Oswald has been a key witness in two American cases in which women who killed family members while taking Halcion claimed that they acted under the influence of the drug. He was to have testified in Utah last year on behalf of Ilo Grundberg, who shot her 83 year old mother eight times, in her $21 million lawsuit against Halcion's manufacturers, Upjohn, but the company settled the case out of court two weeks before the trial date.

In the latest case a Missouri woman, Nila Wacaser, who killed her two sons while taking Halcion, committed suicide in her cell last spring after being found guilty of their murder. Upjohn is appealing against a judge's decision to lift a confidentiality order on company documents used in the case, mainly memos and testing data. If the order is upheld it will be the first time the company has been required to make internal documents about Halcion public.

Upjohn is continuing to fight the UK drug licensing authority's decision to make the ban on Halcion permanent. The company has invoked a rarely used procedure under the Medicines Act, which allows it to make representations to a person or persons—probably a QC and medical assessors—appointed for the purpose by the health secretary. The company is also suing Professor Oswald for libel over statements made to the *New York Times* about clinical trial reports on Halcion submitted to drug regulatory authorities.

An Upjohn spokesman said that there was insufficient information to comment on the court cases. He added: "We continue to say that Halcion is safe and effective when used as directed. We believe it has no different profile from any of the other benzodiazepines."—CLARE DYER, legal correspondent, *BMJ*

The Week

First London, then Glasgow

As London holds its breath wondering what Tomlinson holds in store (see p 719), it's perhaps time to remember that London is not the only city with too many beds, hospitals, and doctors for its population. Many cities have lost populations, while hospitals and health care infrastructure have remained rigidly central. No city, not even London, illustrates this more clearly than Glasgow.

Greater Glasgow Health Board provides health care to just under a million people (19% of the Scottish population) living in an area that crosses several local authority boundaries. Over the past 20 years the population has fallen by 20-25%. Despite Glasgow's resurgence as a city of culture, it remains deeply deprived. It accounts for almost half of the postcode sectors described as deprived in Scotland and on measures of health comes out worst in Scotland—which already has worse health than the rest of the United Kingdom.

Glasgow has lost funds because of its falling population, but its problems have been exacerbated by having to provide health care from some 49 sites (not including primary care). Even major acute services are split between the Victoria, the Southern, the Royal, the Western, and Gartnavel Hospitals, with general paediatrics concentrated in the children's hospital but neonatal care provided at four sites. Within this service the health board employs over 1100 junior doctors.

The roots of this muddle are mainly historical: pre-NHS charitable hospitals were absorbed without challenge into a health service that then failed to plan. Some of the health board's recent attempts to rationalise services have foundered because they have ignored medical advice and proved unworkable. But doctors too share some of the blame: they have been too willing to defend their territory and sometimes to avoid contributing to rational planning.

What has brought the issue to a head is a combination of the juniors' new deal and the NHS market. Rationalisation of services is one plank in the juniors' new deal on reduced hours of work. Without rationalisation it may be impossible for all junior posts in Glasgow to meet the agreed limits on hours.

Glasgow has also traditionally treated many patients from outside its area, and their home health boards will probably no longer want to place contracts in Glasgow. Hence the recognition in Greater Glasgow Health Board's recently published local health strategy that hospital services have to be reorganised: that bed numbers need to reduce, that specialist services need to be more concentrated, and that community, primary care, and long stay facilities need bolstering. That recognition is not, however, accompanied by any suggestions about how rationalisation might happen. Though ministers have hinted that the Tomlinson model might be applied elsewhere, as yet there is no sign of a Scottish Tomlinson, and whether trusts will help or hinder the process is unknown. Certainly, one applicant for trust status—a combined community and acute service for children—promises a model integrated child health service for the city (and that idea came from the paediatricians, not the health board). But other applications will make planning harder. Cynics say, however, that the health board's solution might be to let several units become trusts and then not place any contracts with one, forcing it to fail.

Perhaps, after all, the NHS reforms might give rise to one genuine experiment. Take two cities with similar problems; provide one (London) with a managed solution; in the other (Glasgow) let the market decide.

HART